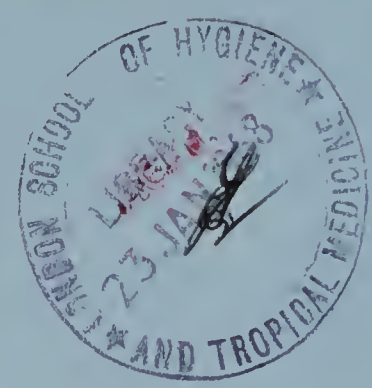


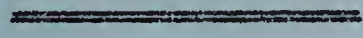
PETERSFIELD URBAN DISTRICT COUNCIL



ANNUAL REPORT
OF THE
MEDICAL OFFICER of HEALTH
AND
PUBLIC HEALTH INSPECTOR

for the year

1962



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THE URBAN DISTRICT COUNCIL OF
PETERSFIELD

Chairman of the Council
(1962-63)

Mr. M.R. Urquhart

Vice Chairman

Mr. H.C. Jacobs

Members of the Council
(1962-63)

Mrs. A.A. Hayes
Mr. P.L. Burley
* Mr. R.D. Warwick
Mr. G.J. Bassett
* Mr. R.H. Fielder

Mr. K. Gammon
* Mr. A.J. Ray
Mr. K.A. Oates
Mr. J.G. Vince
* Mr. G. Owens

Chairman of the Health
Committee

Mr. R.H. Fielder

* Members of the Health Committee

PUBLIC HEALTH OFFICERS

Medical Officer of Health

S. Chalmers Parry, M.A., Cantab., M.R.C.S., L.R.C.P., D.P.H.

Public Health Inspector and Meat and Food Inspector
F.G. Bradley, M.A.P.H.I., (cert. Meat and Foods R.S.H.)

Clerk (part-time) Miss T.F. Smyth.

PETERSFIELD URBAN DISTRICT COUNCIL.

Health Department,
Town Hall,
Petersfield.

To the Chairman and Members
of the Petersfield Urban District Council,

I have the honour to present the Annual Report for the year 1962 on the health and sanitary circumstances of the Urban District of Petersfield. It is drafted in accordance with the requirements of the Ministry of Health.

The population showed an increase of 240 over the 1961 figure.

There has been very little infectious disease.

In February, oral poliomyelitis vaccine was first made available for routine immunisation of special groups as an alternative to the inactivated Salk vaccine.

The percentage of children, born during the year 1961, and immunised before the age of one year, was 67.9%. Parents are again reminded that their children should be immunised in the first year of life.

The value of safety precautions in the prevention of accidents in the home, on the road and in the water is emphasized.

Numbers of school children have been taught to swim in the new Petersfield Swimming Pool since May 1962 when it was opened. The committee is indeed to be congratulated on the success of their enterprise which has proved a great boon and invaluable in the school programme of physical education.

I am grateful to Mr. Bradley for his valuable co-operation and assistance in compiling this report and also for his help in the administration of the Health Department.

It is with profound regret that I record the sad death of Mr. Bradley who worked so conscientiously for the Council and whose complete report is included.

It will be noted in his report that there was a further substantial increase in slaughtering. The overall increase per year since decentralisation in 1955 was 17,554 animals - representing an average increase of about 2,500 carcasses per year. A big increase in slaughtering occurred over the last three years when the figures rose by 10,214 per annum.

S. Chalmers Parry.

Medical Officer of Health.

STATISTICS OF THE AREA

Area	-	-	-	-	2,771 acres
Rateable Value at 1st April, 1963				-	£349,128
Estimated Product of a penny rate 1963/64	-				£1,390
"Home" Population, mid 1962	-			-	7,730
Number of inhabited houses and flats				-	2,537

NATURAL AND SOCIAL CONDITIONS OF THE AREA

The District is situated in Eastern Hampshire bordering on West Sussex.

The predominant geographical features are the South Downs which lie to the South, and Stoner Hill district which lies to the West.

Petersfield is a market town and shopping centre for the surrounding districts.

The district is mainly residential, but there are a few light industries the principal one being a rubber works

The open space known as The Heath includes a boating lake, cricket ground, tennis court and golf course.

Playing fields are provided at Love Lane and children's playgrounds are situated at Bell Hill and Sheet.

A Swimming Bath was opened in 1962 at the rear of the Town Hall.

LEGISLATION OF PUBLIC HEALTH SIGNIFICANCE

The National Assistance (Amendment) Act 1962

This Act gives the widest possible power to Local Authorities to make arrangements for providing meals and recreation for old people.

Landlord and Tenant Act 1962

A rent book is now required for all weekly tenancies. Local Authorities have power to prosecute breaches of this Act.

Food Hygiene (General) Regulations 1962

These regulations make minor amendments to the Food Hygiene Regulations 1960, such as specifying certain food which must not be prepared on Domestic Premises.

Housing (Management of Houses in multiple occupation) Regulations 1962

Managers of any house let in lodgings or occupied by more than one family are required to ensure the good order, repair and cleanliness of the water supply, drainage, lighting and heating, ventilation, disposal of refuse, means of escape in case of fire, common rooms and passages.

These regulations prescribe a code of management which Local Authorities may apply by order to any such house, which is in an unsatisfactory condition in consequence of defective management.

Oil Heaters Regulations 1962

These regulations prescribe safety provisions to be observed by manufacturers of oil heaters.

Emulsifiers and Stabilisers in Food Regulations 1962

These regulations prescribe a list of permitted emulsifiers and stabilisers which may be added to food.

Milk and Dairies (Emulsifiers and Stabilisers) Regulations 1962

These regulations prohibit the sale of liquid milk to which any emulsifier or stabiliser has been added.

Preservatives in Food Regulations 1962

These regulations prescribe permitted preservatives and specify the maximum amount which may be added to food.

Milk and Dairies (Preservatives) Regulations 1962

All preservative are prohibited in milk.

VITAL STATISTICSBIRTHS

	M.	<u>1962</u> F.	Total	M.	<u>1961</u> F.	Total
Live Births (Legitimate)	67	66	133	64	52	116
" " (Illegitimate)	1	3	<u>4</u>	3	1	<u>4</u>
			<u>137</u>			<u>120</u>

Live Birth rate per 1,000 of the estimated "Home" population (mid 1962) was 17.72 compared with 18.00 for the whole of England and Wales.

Illegitimate live births per cent of total births - 2.9

	M.	<u>1962</u> F.	Total	M.	<u>1961</u> F.	Total
Still Births (Legitimate)	-	-	-	1	1	2
" " (Illegitimate)	-	-	-	-	-	-
			-			<u>2</u>

Still Birth rate per 1,000 total (live and still) births was 0.0 compared with 18.1 for the whole of England and Wales.

DEATHS

	M.	<u>1962</u> F.	Total	M.	<u>1961</u> F.	Total
From all causes	58	53	111	54	52	106

Death Rate per 1,000 estimated "Home" population was 14.37 compared with 11.9 for the whole of England and Wales.

MATERNAL MORTALITY

	<u>1962</u>	<u>1961</u>
Pregnancy, Childbirth & Abortion	Nil.	Nil.
From other Puerperal Causes	Nil.	Nil.

Maternal Mortality rate per 1,000 total (live and still) births 0.0

INFANT MORTALITY (deaths under one year) -

	M.	<u>1962</u> F.	Total	M.	<u>1961</u> F.	Total
Legitimate	1	1	2	2	2	4
Illegitimate	-	-	-	-	-	-
			<u>2</u>			<u>4</u>

Infant Mortality Rate per 1,000 live births was 14.6 compared with 21.6 for the whole of England and Wales.

The number of deaths of infants under the age of one year per 1,000 live births is known as the infant mortality rate for that year.

This rate for each calendar year is not regarded as a reliable guide, for the number of births in the District is insufficient to be of significance statistically; but, if this rate is taken over a period of five years, it may then be considered reasonably reliable. High rates are commonly associated with overcrowding and defective sanitation.

It is, therefore, satisfactory to report that during the past years the quinquennial rates for this district have been consistently lower than the figures for the country as a whole.

The following table shows the rate for the district as compared with the rate of England and Wales, each over a five-year period.

Year	Petersfield U.D.C.		England and Wales	
1946	-	-	36.71	42.0
1947	-	-	32.41	39.2
1948	-	-	26.35	35.9
1949	-	-	19.85	33.3
1950	-	-	11.45	30.6
1951	-	-	10.51	29.2
1952	-	-	14.85	28.2
1953	-	-	11.32	26.88
1954	-	-	13.11	25.76
1955	-	-	17.26	24.24
1956	-	-	13.78	23.96
1957	-	-	11.09	23.24
1958	-	-	13.09	22.60
1959	-	-	17.80	22.48
1960	-	-	17.50	21.88

The infant mortality rate of the year under review was 14.6 compared with 21.6 for England and Wales.

The corresponding figure for 1961 was 33.3 compared with 24.4 for England and Wales.

CAUSES OF DEATH.

		Male.	Female.	Total.
1.	Tuberculosis of Respiratory System -	-	-	-
2.	Other forms of Tuberculosis -	-	-	-
3.	Syphilis - - -	-	-	-
4.	Diphtheria - - -	-	-	-
5.	Whooping Cough - - -	-	-	-
6.	Meningococcal Infections - - -	-	-	-
7.	Acute Poliomyelitis - - -	-	-	-
8.	Measles - - -	-	-	-
9.	Other Infective and Parasitic Diseases -	-	-	-
10.	Malignant Neoplasms Stomach -	1	-	1
11.	" " Lungs, Bronchus -	2	1	3
12.	" " Breast -	-	3	3
13.	" " Uterus -	-	1	1
14.	Other Malignant & Lymphatic Neoplasms -	9	4	13
15.	Leukaemia, Aleukaemia - - -	-	-	-
16.	Diabetes - - -	1	-	1
17.	Vascular Lesions of Nervous System -	10	14	24
18.	Coronary Disease, Angina - - -	8	3	11
19.	Hypertension with Heart Disease - - -	-	-	-
20.	Other Heart Disease - - -	14	15	29
21.	Other Circulatory Diseases - - -	4	1	5
22.	Influenza - - -	-	2	2
23.	Pneumonia - - -	2	3	5
24.	Bronchitis - - -	3	-	3
25.	Other Diseases of Respiratory System -	-	-	-
26.	Ulcer of Stomach & Duodenum - - -	-	-	-
27.	Gastritis, Enteritis & Diarrhoea - - -	-	1	1
28.	Nephritis & Nephrosis - - -	-	-	-
29.	Hyperplasia of Prostate - - -	-	-	-
30.	Pregnancy, Childbirth - - -	-	-	-
31.	Congenital Malformations - - -	1	-	1
32.	Other Defined and Ill-defined Diseases -	1	2	3
33.	Motor Vehicle Accidents - - -	1	-	1
34.	All other Accidents - - -	1	1	2
35.	Suicide - - -	-	2	2
36.	Homicide & Operations of War - - -	-	-	-
TOTALS -		58	53	111

ANALYSIS OF THE CAUSES OF DEATH - ACCORDING TO AGE.

Causes of Death.

Age Groups.

	0-1 M F	1-10 M F	10-20 M F	20-30 M F	30-40 M F	40-50 M F	50-60 M F	60-70 M F	70-80 M F	80-90 M F	90-100 M F	100 M F	Total
Malignant Neoplasms													
Stomach													1
Lungs								1 -	1 -				3
Breast							- 2	- 1		- 1			3
Uterus								- 1					1
Other Malignant Neoplasms				1 -	- 1			2 2	1 -	5 -	- 1		13
Influenza									- 1	- 1			2
Vascular Lesions of Nervous System							1 -	1 4	3 3	5 5	- 1		24
Coronary Disease - Angina					- 1		2 -	3 -	1 1	2 1	- 1		11
Other Heart Diseases							1 -	4 3	5 4	4 5	1 2		29
Other Circulatory Disease				1 -									
Pneumonia	- 1							1 -		3 1	- 1		5
Bronchitis							1 -	1 -		1 1			5
Gastritis and Diarrhoea								- 1					3
Other Defined and Ill-defined Diseases	- 1		1 -					- 1					1
Motor Vehicle Accidents									1 -				3
All other Accidents					- 1		1 -						1
Diabetes													2
Congenital Malformation	1 -						- 1	- 1					1
Suicide													1
TOTALS -	1 2	- -	1 -	2 -	- 3	- -	5 4	13 14	13 9	21 15	1 6	1 -	111

GENERAL PROVISION OF HEALTH SERVICES FOR
THE AREA.

AMBULANCE FACILITIES

All applications for the use of ambulances should now be directed to the Ambulance Officer, Fareham (Telephone: ~~Fareham 2170~~) who arranges for the most conveniently situated ambulance to attend. Titchfield 3126

Smallpox cases (suspected or confirmed) requiring transport to hospital will be conveyed by the County Ambulance Service by arrangements made through the Winchester Hospital Management Committee (Telephone: Winchester 5151).

HOSPITAL CAR SERVICE

The use of this service may be obtained through the Ambulance Officer (Telephone: ~~Fareham 3626~~). Titchfield 3225
2397

LABORATORY FACILITIES

Bacteriological work is carried out by the Public Health Laboratory at the Royal Hampshire County Hospital, Winchester (Telephone: Winchester 3807) and specimens of clinical materials (sputum, swabs, etc.) and samples of water, milk and foodstuffs are sent for bacteriological examination to Dr. M.K. Hughes, Director of the Public Health Laboratory. Specimens may be deposited in the samples box placed outside the laboratory, or they may be left at the Main Hall of the Royal Hampshire County Hospital at any time when the laboratory is closed. At week ends, and on public holidays, arrangements are made for dealing with specimens during the morning and evening. URGENT specimens can be dealt with at any time and the Director, Doctor M.K. Hughes is available at Twyford 3349 for telephone consultation when he is not in the laboratory.

Some specimens, in connection with cases of infectious diseases, which have been admitted to the Portsmouth Infectious Diseases Hospital are sent for bacteriological examination to Dr. K. Hughes, Director of the Public Health Laboratory, Milton, Portsmouth (Telephone: Portsmouth 74531). These may be left at the Porter's Lodge, of the Infectious Diseases Hospital at any time. URGENT specimens can be dealt with, when the laboratory is closed, by telephoning the technician on call at St. Mary's Hospital (Portsmouth 22331).

Samples of water, sewage, milk etc. for chemical analyses are sent to the City Analyst, Portsmouth. (Telephone: Portsmouth 5472).

NURSING IN THE HOME

There are two district nurse/midwives practising in Petersfield. Mrs. M. C. Lapper, S.R.N., S.C.M., (Queen's Nurse, 153 The Causeway, Petersfield, (Telephone: Petersfield 628), carries out her duties in south Petersfield; and Mrs. E. M. Percy, S.R.N., S.C.M., 22 Queens Road, Petersfield (Telephone: Petersfield 676) serves Stroud, Sheet and north Petersfield

HEALTH VISITING SERVICE

Miss E. J. Read, S.R.N., S.C.M., A.R.S.H., Church Cottage, West Meon (Telephone: West Meon 315) carries out the Public Health Work in the district under the direction of the County Medical Officer.

MATERNITY CASES

The Grange Nursing Home, Liss and Northlands Maternity Home, Emsworth, are available for admission of maternity cases. Applications are generally made to the County Medical Officer who arranges for a home visit by the Health Visitor.

HOME HELP SERVICE

The Home Help Divisional Office is situated at the rear of the Town Hall, Petersfield (Telephone Petersfield 771 Extension 18) and is open Mondays to Fridays, 9 a.m. - 12 noon, when Mrs. Holmes or her clerical assistant Mrs. Wilson will be available. Application for Home Help should be made to this office. Urgent messages can be left at the Town Hall up to 5.30 p.m. Monday to Friday; evenings and weekends Telephone Horndean 3516.

The Area covered by this Division consists of Petersfield Urban and Rural Districts, Droxford Rural District, and Alton Urban and Rural Districts.

CLINICS

The following clinics are held at the County Council Health Clinic, Love Lane, Petersfield (Telephone: Petersfield 20).

Ophthalmic Clinic	- - - -	By appointment on Second Tuesday afternoons and the second and fourth Thursday mornings in each month.
Child Welfare Clinic	- - - -	Wednesday mornings and afternoons.
School Clinic	- - - -	By appointment
Dental Clinic	- - - -	For an appointment to be fixed, telephone Petersfield 954 between 9 a.m. and 9.15 a.m. (Mondays to Fridays)
Speech Therapy Clinic	- - - -	Monday afternoons by appointment.

CHILD WELFARE CLINIC

The Child Welfare Clinic is held every Wednesday morning and afternoon at the County Council Health Clinic, Petersfield. The work of the voluntary helpers, who assist the medical and nursing staff at the clinic, is greatly appreciated.

FAMILY PLANNING ASSOCIATION CLINICS

Advice on family planning is given at the following clinics which are run on a voluntary basis as the service is not available under the National Health Service. A lady doctor and sister are in attendance.

AREA	ADDRESS OF CLINIC	DAY	TIME
Cosham	Child Welfare Clinic, Northern Road.	Every Wednesday	1.30 to 3.30 p.m.
Eastleigh	The Red House, 6, Romsey Road.	Every Friday	1.30 to 3.30 p.m.
Fareham	County Council Health Clinic, Assembly Hall, West Street.	Every Monday	5.00 to 7.00 p.m. New patients by appointment
Portsmouth	Trafalgar Place, Clive Road, Fratton.	Tuesdays & Fridays	1.30 to 3.30 p.m. 6.00 to 8.00 p.m.
Winchester	The Hut (adjoining Trafalgar House) Trafalgar Street.	Every Tuesday	2.00 to 4.00 p.m.

Any further information can be obtained from the County Medical Officer.

It is desirable that a women should, at her first attendance, take to the clinic a letter from her own doctor.

CHEST CLINIC

A Chest Clinic is held at the Queen Alexandra Hospital, Cosham, (Telephone: Cosham 79451, Extension 114) :-

Mondays	9.30 a.m. to 12.30 p.m.	Old Patients.
	1.30 p.m. to 5.00 p.m.	Old Patients.
Wednesdays	2.00 p.m.	Skin Testing.
Thursdays	2.00 p.m. to 5.00 p.m.	Refills.

Dr. J. P. Sharp, the Chest Physician is in attendance.

A Clinic is also available at the Chest Clinic, Royal Hants. County Hospital, Winchester, every Wednesday at 10 a.m. to 12.30 p.m. (Old Patients) and 2 p.m. to 4.30 p.m. (New Patients) and Thursday at 10 a.m. to 12.30 p.m. Dr. A. Capes, Chest Physician is in attendance (Telephone: 5151, Extension 347).

* VENEREAL DISEASES

Treatment is available at St. Mary's Hospital, Portsmouth:-

Males: Tuesdays and Thursdays 10 a.m. to 12 noon, and 5 p.m. to 7 p.m.
Females: Mondays 5 p.m. to 7 p.m., Wednesdays 2 p.m. to 4 p.m., and
Fridays 10 a.m. to 12 noon

SCHOOL HEALTH SERVICES.

* ORTHOPAEDIC CLINICS

Orthopaedic cases, requiring treatment, are seen by appointment from the Appointments Officer of each hospital.

<u>Alton</u>	Surgeon's Clinic held at Lord Mayor Treloar Hospital on Fridays.
	Remedial Clinic held at Lord Mayor Treloar Hospital daily.
<u>Havant</u>	Surgeon's Clinic held at Havant War Memorial Hospital on fourth Tuesday afternoons.
	Remedial Clinic held at County Council Health Clinic on Tuesdays all day (except 4th Tuesday afternoon) and Wednesday all day.
<u>Petersfield</u>	Remedial Clinic held at Petersfield General Hospital as required.
	Orthopaedic cases requiring remedial treatment are referred to this Clinic.

* OPHTHALMIC CLINIC

This is held for school and pre-school children at the County Council Health Clinic, Love Lane, on the second Tuesday afternoon and the second and fourth Thursday mornings, each month by appointment.

* ORTHOPTIC CLINIC

Cases selected by the School Oculist are referred to the Eye and Ear Hospital, Portsmouth.

* EAR, NOSE AND THROAT CLINICS

Cases referred for specialist advice are examined at the Portsmouth Eye and Ear Hospital and Treatment is carried out either at that Hospital or at Petersfield Hospital.

SCHOOL CLINIC

This is held at the County Council Health Clinic, Love Lane, Petersfield, by appointment.

SPEECH THERAPY CLINIC

Cases attend at the County Council Health Clinic, Love Lane, Petersfield on Monday at 1.30 p.m. by appointment.

CHILD GUIDANCE CLINIC

Cases are seen by appointment at the County Council Health Clinic, Dunsbury Way, Havant, or Trafalgar House, **Winchester.**

DENTAL CLINIC

Dental Clinics for treatment of school children expectant and nursing mothers, are held as required at the schools and at the County Council Health Clinic, Love Lane, (Telephone: Petersfield 954 between 9 a.m. and 9.15 a.m. for appointment).

* These services are the responsibility of the Regional Hospital Board.

HOSPITALSGENERAL

There are five general hospitals available for the admission of patients from Petersfield :-

Petersfield General Hospital

The Petersfield Hospital (Telephone: Petersfield 1221, 1222) has twenty four beds available for medical and surgical cases. It is administered by the Portsmouth Group Hospital Management Committee.

The Royal Portsmouth Hospital, Portsmouth (Telephone: Portsmouth 22281).

St. Mary's Hospital, Portsmouth (Telephone: Portsmouth 22331).

Royal Hampshire County Hospital, Winchester (Telephone: Winchester 5151).

Queen Alexandra Hospital, Cosham (Telephone: Cosham 79451).

HEATHSIDE HOSPITAL, PETERSFIELD

This institution, which is under the control of the same Committee as the General Hospital, Petersfield, has been utilised for the care of chronic sick patients since the 1st October, 1949. There are 40 beds.

INFECTIOUS DISEASES

Since the closure of the Petersfield Infectious Diseases Hospital, there is no infectious diseases hospital situated in the district.

ANY infectious diseases hospital is now available for the admission of cases occurring in the district. Patients are generally admitted to Priorsdean Hospital, Milton Road, (Telephone: Portsmouth 22331) which is under control of the Regional Hospital Board.

Special arrangements have been made for the admission of children suffering from acute poliomyelitis to Lord Mayor Treloar Hospital, Alton, (Telephone: Alton 2238).

SANATORIA

Sanatoria for patients who are suffering from Tuberculosis are provided by the Regional Hospital Board.

SMALLPOX

The Regional Hospital Board makes provision for the treatment of cases of smallpox at Weyhill Hospital, Andover. Requests for admission to Weyhill should be made to the Group Secretary of Winchester Group Hospital Management Committee (Telephone: Winchester 5151) between the hours of 9.00 a.m. and 5.00 p.m. or to the Duty Officer at the Royal Hampshire County Hospital (Winchester 5151) out of office hours.

HOUSING.PROVISION OF NEW HOUSES

During the year 3 houses were completed by the Council. 39 houses were built by private enterprise.

IMPROVEMENT GRANTS.

There are two kinds of grant available to landlords and to owner/occupiers for improving houses erected before 1945.

1. Discretionary Grants: Subject to certain conditions* up to half the estimated cost of a wide range of improvements may be paid, at the discretion of the Local Council, subject to a maximum of £400. These grants are available also for the conversion of houses into flats.

2. Standard Grant: In some circumstances* house owners and certain leaseholders can obtain, as a right, half the cost, up to a maximum grant of £155. for providing five basic amenities:-

(a)	bath or shower in a bathroom	£25
(b)	wash-hand basin	£5
(c)	water closet	£40
(d)	hot water supply	£75
(e)	food store	£10
		<u>£155.</u>

*Further information is contained in the pamphlet entitled "Improve your house with a grant". Copies are available at the Council Offices.

During 1962 twenty-three improvement grants were paid by the Council, in respect of improvements to twenty-three houses, ten were standard grants.

INSPECTION AND SUPERVISION OF FOOD.

MILK SUPPLY

The Food and Drugs (Milk and Dairies) Act, 1944, is the principal Act dealing with milk production and distribution.

The Ministry of Agriculture, Fisheries and Food is responsible for the supervision of milk production on the farms, whilst Local Authorities control milk distributors and retail dairies.

The Milk (Special Designation) Act, 1949 and Regulations made thereunder, deal with the issue of licences for the following grades of milk:-

1. Tuberculin Tested.
2. Pasteurised.
3. Sterilised.

The Hampshire County Council, which is the Food and Drugs Authority in this district, delegated its functions under the Milk (Special Designations) Regulations, 1960, to the Councils of County Districts who will continue the supervision and sampling of Pasteurisation Plants and the granting of licences to sell Tuberculin Tested and Sterilised milk.

1. Tuberculin Tested.

Milk licences to produce this grade of milk are issued by the Ministry of Agriculture, Fisheries and Food.

Six "Dealers" Licences were issued during the year.

2. Pasteurised Milk.

The Act places responsibility on Foods and Drugs Authorities for issuing licences to Pasteurise.

Two kinds of pasteurising plants are permitted by the Regulations: (1) "Holder Type" in which the milk is held at a temperature of 145° - 150° F. for thirty minutes; (2) H.T.S.T. plants in which the minimum temperature is 161° F. and the milk is held for fifteen seconds.

One licence to produce Pasteurised Milk was issued by this Council in 1961.

In addition, five "Dealers" Licences to sell Pasteurised Milk were issued during the year.

3. Sterilised Milk.

The regulations require that milk should be filtered and clarified, homogenised and heated to and maintained at not less than 212° F. for such a period as to ensure that it will comply with a turbidity test as prescribed in the regulations. There are no plants for the production of this grade of milk in the Urban District, but six "Dealers" Licences were issued.

All licences issued in 1961 are for a fine year period expiring in 1965.

P R E V E N T I V E M E A S U R E S

FOOD HYGIENE

Personal Hygiene

In normal circumstances, we all wash our hands with soap and hot water before handling food and immediately after using the toilet. This practice is absolutely essential for everybody, for toilet paper is porous; and, once contaminated, the hands will leave bacteria behind on everything they touch. Licking the fingers or touching the hair, lips or nose or a soiled handkerchief cancels the benefit of a previous wash. Short nails are more easily kept clean. "No touch" technique should be practised whenever possible; where handling is an essential process, germicidal creams, applied after careful hand-washing, have been found effective.

Precautions

It should constantly be borne in mind by all concerned in the handling, preparation and storage of food - particularly by those who work in canteens or who serve food to large numbers - that the utmost care must be taken to obviate the risk of food poisoning, which may occur even in the best equipped canteens.

Any food handler should report to his employers:-

- (1) Diarrhoea or vomiting.
- (2) Septic cuts or sores, boils or whitlows.
- (3) Discharges from the ear, eye or nose.
- (4) Typhoid fever, paratyphoid fever or any other salmonella infection, dysentery or any staphylococcal infection likely to cause food poisoning or being a "carrier" of any of these illnesses.

Housewives and foodhandlers should cover, with a water-proof dressing, any exposed sore or wound they have - particularly on their hands and arms - as infections are quickly spread in this way. For a finger wound, a rubber finger-stall is a safe-guard while food is being handled.

Customers have now become more clean food minded and are more inclined to complain to the management when they notice any obvious unhygienic practices.

The hygiene standard of these shops and restaurants therefore lies to some extent in housewives' hands.

A high standard of hygiene is a benefit to food traders, for it attracts business; and it is of course all in the interest of the general public to encourage safer practices.

Cakes, boiled sweets, cooked food and vulnerable foods should be handled by tongs or servers and not fingered by the hands, for they are never clean enough safely to handle food of this nature.

Protection

Vulnerable foods - which include pressed meat, brawn, meat pies, stews, trifles, custards and synthetic cream - are normally quite safe when prepared, but they act as ideal breeding grounds for any dangerous germs that gain access, and, if kept at warm temperature, the germs will multiply very rapidly.

Made up meat dishes and other vulnerable foods provide a perfect medium for the growth and multiplication of bacteria.

Special care and attention is needed in the selection, the handling and the storage of food in summer because bacteria multiply more quickly in warm weather - and the harmful ones cause food poisoning. Most of the family outbreaks happen in the summer time.

The ordinary group of food poisoning organisms (i.e. the Salmonellae) are killed at high temperatures, but the fact that a product is to be heat-treated is no absolute safeguard against any spread - as the infection is often carried from the raw material on the hands and utensils to some article of food in the same premises, which is either already cooked or not subject to heat treatment.

Prevention

There is, however, another type of germ that is not killed by heat and does not require the presence of air for it to produce its toxins; so, as long as the temperature conditions are suitable and the intervals of time between the end of cooking and the consumption of food are sufficiently long for the organism to survive and breed, there is always a possibility of its giving rise to food poisoning.

This organism (Cl. Welchii) is not uncommonly found in meat, so, the sooner meat is eaten after cooking, the less likelihood there is for cases of food poisoning from this source of infection to occur. As this organism is fairly widespread in nature, methods prevention must be concentrated far more on care over cooking and storage.

As a general rule, meat - whether as cuts or in pies or stews - should be thoroughly cooked and eaten hot; if this is impossible, it should be cooled rapidly within $1\frac{1}{2}$ hours of cooking and refrigerated until required. In any event, there should be the shortest possible time between cooking and eating in order to limit the number of organisms; for it is only when they have been allowed to multiply that trouble will occur.

The size of cuts is of some importance from the public health point of view; for the rate of penetration and loss of heat is proportional to the size of the joint. Meat, sliced after cooking, should be kept cold.

For minces, meat should be minced when raw and eaten freshly cooked; stockpots are a hazard, and the same chopping board should not be used for both raw and cooked meat.

Food Hygiene

Re-handled and re-heated meat is still the main villain of the piece. In fact, in 1961, two thirds of the outbreaks, traced to a specific cause, were associated with cold meats which had been re-handled, made-up meats (such as meat pies) and re-heated dishes (such as stews and shepherd's pie).

Soups, stews, gravies, pies, pease-pudding, etc., provide even better conditions for the multiplication of the germs than solid meat. Gravy should never be re-heated; soup and stock, if re-heated, must be boiled.

Pressure cooking must be considered one of the safest measures against the survival of spores.

But emphasis should rightly be placed on methods of preventing the food from becoming contaminated in the first place.

Undercooking

Apart from bacterial and toxin poisoning, which can be conveyed by undercooked food, there is the additional danger of worms and flukes being transmitted to man by eating infected meat, fish, shellfish or watercress.

Infected pork and pork products, when insufficiently cooked, can cause human infection with tapeworm or trichinosis and undercooked beef, infected with tapeworm, can cause tapeworm in man.

Fluke disease, which is a serious disease in man, can be transmitted to him by eating infected watercress. In the prevention of this disease, housewives are warned not to buy watercress from casual sources and are advised to buy only from accredited traders.

Cattle should be kept right away from watercress beds and from streams passing through their pasture land.

Cooling and Refrigeration

Many outbreaks of bacterial food poisoning would never have occurred if the food, after being cooked, had been rapidly cooled and then placed in a refrigerator until actually required, instead of being left at room temperature overnight and then eaten cold, or warmed up the next day. Food poisoning organisms will multiply and produce food poisoning only if food is kept under certain temperature and moisture conditions over a period of time.

If meat is cooked and allowed to cool slowly in a warm or humid kitchen, or in a warm oven where it has been cooked, any germs, deposited on it from the hands, increase rapidly. Even warming it up later in a stew or mince may not be sufficient to kill off harmful bacteria. All food should be thoroughly cooked and, if not required for immediate consumption, rapidly cooked.

A well ventilated larder or suitably sited safe, preferably with a through-draught or fan, helps good and efficient cooling. A marble slab is invaluable for the cool shelf in a larder and, even here, the food must be carefully protected against flies.

As soon as it is cooled, meat can be placed in an icebox, or, better still, in a refrigerator, if available.

Refrigerators were frequently regarded as luxuries; but people are now more "refrigerator-minded" although often unaware of the important role it plays in the prevention of food poisoning.

The three groups of bacteria - Salmonella, Staphylococcus and Clostridium Welchii - cause food poisoning only after growth and multiplication in the food.

Growth is prevented only at a refrigeration temperature of 4°C . or below.

Where cold rooms are not available, the hot meat should be left in a cool draughty place for $1\frac{1}{2}$ hours before storage in the domestic type of refrigerator.

Refrigeration conserves food in a wholesome and palatable condition and definitely retards the growth of bacteria, if they are present. It is, therefore, most important that vulnerable foods such as gravy, soup, stock, custard and cake fillings, on which food poisoning bacteria can increase easily, should be stored at a low temperature in a refrigerator or a cool larder to prevent the germs from multiplying.

It is not generally appreciated that the germs which commonly cause food poisoning do not necessarily alter the smell, taste or appearance of the food.

Practice

The Chief Medical Officer to the Ministry of Health has stated:-

"The remedy is largely in the hands of caterers. Nowadays there is little excuse for unhygienic practice in the preparation and serving of food: the risks are well known and the simple methods by which they may be avoided are within the reach of all. That they are not practised is a direct reflection upon the management responsible."

A high standard of hygiene for food traders is best obtained by observing the following simple rules:-

- (1) Protection of food from all sources of contamination (dust and droplet infection as well as from flies, cockroaches, rats and mice).
- (2) Personal cleanliness of "food non-handlers".
- (3) Proper storage and display of food at a safe temperature.

A recent report from the Public Health Laboratory Service on Food Poisoning in England and Wales, states: "Good hygiene and the exclusion from food handling of persons with septic lesions on the skin will not by themselves ensure the safety of such frequently implicated foods as brawn, pressed meats, ham and bacon, - the additional measure is refrigeration."

As a regular customer, the housewife can, however, influence traders by making it clear that she only chooses those who take special care to ensure the freshness and cleanliness and good storage of foods which they sell.

Protection of the public and family lies in personal hygiene, kitchen hygiene and the good management of the buying, storing, cooking and cooling of the food.

Routine inspection of food premises is proceeding and any complaints received by this department are thoroughly investigated.

In this connection, the Health Department would be glad to receive from the general public complaints of unhygienic methods practised in any food shops.

Food Poisoning Statistics 1952 - 61
(Public Health Laboratory Service)

Year	General Outbreaks	Family Outbreaks	Sporadic Cases	Total Incidents
1952	372	340	2,807	3,519
1953	492	422	4,363	5,277
1954	506	630	4,880	6,016
1955	612	723	7,626	8,961
1956	563	616	6,534	7,713
1957	473	501	6,097	7,071
1958	285	601	6,414	7,300
1959	295	666	6,885	6,428
1960	262	616	5,550	6,428
1961	229	490	4,668	5,387

Throughout the whole of the past decade, the most striking feature has been the enormous number of "sporadic" cases isolated. (For every recorded outbreak involving 20 or more persons there were approximately 50 isolated or familial infections).

Figures in the above table clearly show that, although the general outbreaks of food poisoning that occur in schools, canteens, hotels and restaurants, etc., have dropped appreciably over the past ten years, family outbreaks are still above the 1952 and 1953 figures. It is only fair, however, to point out that these have decreased considerably since 1954.

But this is no time for complacency, for these thousands of "incidents" represent many more thousands of people affected and show the need for more awareness amongst householders.

It is, however, very reassuring to note that, during 1961, there was a reduction of 16% over the 1960 food poisoning incidents. There has been a decrease in all types of food poisoning; in general outbreaks, a reduction of 12½%, family outbreaks 20½%, and sporadic outbreaks 15.9%. The improvements in public catering may well be reflecting some good results of health education. The greatest decrease (37%) was in incidents in which the causal agent was not discovered.

In 1961, two thirds of outbreaks, traced to specific cause, were associated with cold meats which had been re-handled, made-up meats (such as meat pies) and re-heated dishes (such as stews and shepherd's pie). As in

previous years, the articles of food most commonly incriminated were processed and made-up meats.

Processed meat was implicated in about half the outbreaks due to salmonellae and staphylococci and almost all the outbreaks due to Cl. Welchii.

There was a slight reduction (5%) in incidents due to salmonellae; but they are a continuing problem arising from the transfer of infection by human contacts or by equipment used in the preparation of the food.

The places, at which contaminated food was bought or eaten, were recorded in 72% of the general outbreaks; canteens and schools were frequently mentioned; but there was a notable reduction in the number of outbreaks in hospitals and institutions.

The organism most commonly responsible for school outbreaks of food poisoning is Clostridium Welchii. Nearly half of the outbreaks (47.2%) in 1960 and (46.85%) in 1961 were due to this cause.

Only four school outbreaks were attributed to salmonella infection in 1961.

Statistics show that people are spending more on food than ever before; and one of the causes of food poisoning in families might be partly due to changes in our food habits. The wide variety of processed foods now available to the housewife - some partly prepared and some deeply frozen - are prepared in excellent and hygienic conditions, and are time and labour saving; but they can easily be contaminated and become a vehicle for food poisoning, if not properly handled and stored.

It is also important to read the instructions carefully on labels of such foods and to comply with the directions for their treatment, cooking and storage.

HEALTH EDUCATION

The Central Council for Health Education has extended its information services to cover the ever widening field of public health.

It continues to supply the department with relevant facts and figures relating to topical subjects and specific problems.

Whilst the food hygiene regulations may help to decrease food poisoning due to organisms other than salmonellae, there will be little difference in the general picture so long as the distribution of contaminated food stuffs is allowed to continue.

In recent years, the search for possible vehicles of infection in the United Kingdom has revealed hitherto unsuspected potential sources of Salmonellae:- American spray dried egg, Chinese and Australian crystalline and liquid egg albumen and liquid whole egg, dessicated coconut from Ceylon, bone meal and fish meal from Central Africa and the Middle East together with imported meats from various European countries.

These imported food stuffs (egg products, dessicated coconut, meats and animal feeding stuffs) have given rise to a vast reservoir of Salmonellae infection.

Research is still proceeding; and it is pointed out that animal feeding stuffs and fertilisers are not however such important sources of human infection as are egg and meat products.

If egg and egg products, meat and meat products, and feeding stuffs and fertilisers could be protected from contamination with salmonellae in the first place, or if all products likely to be contaminated with salmonella could be adequately heat-treated, the incidence of food poisoning would fall considerably.

Authorities state there is no evidence to show that food poisoning organisms are present in the flora of newly caught fish or that fish suffer from salmonella infection; but the situation is quite different with poultry or meat. Salmonellae are often present in the intestines of both diseased and healthy animals. The infection may easily be spread in slaughterhouses and food shops or kitchens by dogs, cats, rats, mice or even pigeons, as each of these species may carry the germ. But infection of beef and beef products appears to occur more frequently after slaughter and possibly after the meat has left the slaughterhouse.

"Prevention of salmonella food poisoning depends on knowing more of the potential sources of contamination and is a long term problem; otherwise the remedies for the elimination of food poisoning are simple and can easily be applied."

For the present, the public should note that fresh meat and fish, cooked and eaten when hot, fresh vegetables and fruit and pasteurised milk and canned foods of all kinds are seldom implicated in food poisoning.

In order to encourage good habits of personal hygiene among members of the staff of catering establishments, housewives and others, the Ministry of Health has prepared several illustrated, coloured posters on the subject of food handling, which are a great asset when linked with routine inspection and supervision.

I am indebted to the Information Division of the Ministry for their help during the year.

BRUCELLOSIS

The cause of Human Brucellosis and Contagious Abortion in cattle is *Brucella Abortus*. Absence of abortion in a herd does not necessarily signify the absence of infection.

The true incidence of human brucellosis in Britain is unknown because the disease is not notifiable. But Dalrymple-Champneys, 1960,¹ estimated its approximate prevalence as 1,300 cases per annum and Bothwell et. al. (1962)² supplied evidence indicating there is no "falling off" in known human cases in recent years and that infected raw milk is the most likely vehicle of infection.

Dalrymple-Champneys reported that only 236 of his 1,500 cases gave a history of occupational risk; whereas 885 (70.5%) had almost certainly been infected through the consumption of contaminated cows' milk or cream.

It has been demonstrated that there is an association between the consumption of brucella infected milk and a high incidence of infection amongst adults and children - much of which is subclinical.

In an excellent report on Brucellosis Control and Eradication by the Oxford Working Group (Bothwell et. al. 1962), it was stated that at present (i.e. 1960/61) occupationally at risk groups account for 20-25 per cent of cases, when both rural and urban districts are taken into account. This figure may be as high as 50 per cent when rural cases are considered alone. They state that the crux of the problem is the infected animals in the dairy herd.

The main reservoir of brucellosis is the apparently normal cow excreting the organism after a full-term parturition.

Stopping the sale of milk from proven infected cows or enforcing the pasteurisation of milk in such cases is merely palliative and plays no part in eradication of disease in a herd. But it does at least eliminate the seventy per cent human cases, quoted above, who have been infected through the consumption of raw milk.

As Brucellosis has no reservoir in man, elimination of the disease in cattle must result in elimination of human disease.

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1. Dalrymple-Champneys, W. (1960): "Brucella Infection and Undulant Fever in Man." London, OUP.
 2. Bothwell, P.W., McDiarmid, A., Bartram, H.G., MacKenzie-Wintle, H.A., and Williamson, A.R. (1962): Vet. Rec., 74, 1091 - 1100

I am indebted to the Divisional Medical Officer, Cheshire, for most of the foregoing summary on "Brucellosis".

The Oxford Working Group and others have clearly pointed out that review of the present legislation in relation to brucellosis is well overdue. In fact, the position is so remarkable that it might almost have happened in Wonderland:

ALICE IS CURIOUS ABOUT MILK³

(With apologies to Lewis Carroll)

Alice was frankly worried. She had heard a lot about Brucellosis lately and wanted to know how she could be sure of not catching it from milk; so, in desperation, she finally turned to the Hatter for advice.

"I like milk; but I only like safe milk," she exclaimed emphatically. "What sort of milk should I get, Sir?" she enquired.

"TT milk of course," replied the Hatter, irritably. "Don't ask stupid questions!"

But that answer did not entirely satisfy Alice who was feeling in an argumentative mood.

"Why do I have to pay more for raw TT milk than for pasteurised milk that I know is safe? Everyone knows TT milk is a clean milk; but surely raw TT milk may have all sorts of germs in it?"

"You pay of course for the fun of the game. It's a gamble; if you are lucky, you will get an immunity - if not, you may get the disease."

"But I don't want to get Brucellosis, Scarlet Fever or any other milk-borne disease", said Alice peevishly.

"If you get one of those diseases and don't die, you'll get some immunity afterwards, so what's the difference? Let's change the subject," replied the Hatter impatiently.

But Alice wasn't going to be put off. "I simply can't understand why they put the Cart before the horse, can you?" she asked, "If only they made Brucellosis of cattle a notifiable disease, the animal doctors would remove the infected cows; then their germs wouldn't get into the milk and give the disease to people with little or no resistance to it."

3. Based on a letter to the Medical Officer, 9th November, 1962, P. 296.

"Very clever", snapped the Hatter, "but don't you know the disease is also caught from the cows themselves?"

"All the more reason for finding and separating the infected cows", thought Alice. But she didn't want to offend the Hatter, so she said as politely as she could, "Like most people, I don't work on a farm or have anything to do with cows and, in any case, I am only asking about milk!"

Alice had shot her bolt, and now she waited for his advice.

The Hatter shook his head and suddenly rocked with laughter, "I suppose you will be saying next that all milk should be pasteurised," he replied scornfully.

"Yes, of course, that's the answer," said Alice triumphantly. "Why ever did I not think of it myself?"

And she thought to herself, "Perhaps the Hatter is not quite so mad after all!"

A C C I D E N T S

(IN THE HOME)

More people are killed by accidents in the home than by accidents on the road, the fact is not really surprising since people spend more time in their houses; but it does mean that we must do everything we can to reduce home accidents.

Over 6,000 persons die annually in England and Wales as a result of accidents in their homes. Most fatalities result from four main causes - falls, poisoning, burns and scalds and suffocations, and of these, about 700 are due to burns and scalds.

More than four-fifths of the fatalities concern the young and the old, and as high a proportion as two-thirds involve infants under one year and elderly people of seventy-five and over who are prone to falls, gas poisoning and burns. The majority of home accidents are preventable.

Thermal Accidents.

Statistics about non-fatal accidents are not available, but it is estimated that each year not less than 50,000 persons need hospital treatment for burns and scalds caused by domestic accidents and that about 80% of the deaths, resulting from extensive burns, are due to clothing coming into contact with the heating element or flame of an unguarded or

inadequately guarded coal, gas, electric or oil heating appliance. "Open" fires are responsible for more fatal accidents than any other type.

Scalds are a much lower death rate than burns, but the incidence nearly equals that of burns and the degree of disfigurement or disablement may be equally severe. They occur most commonly in children under five years of age, and the most serious accidents result from children falling into buckets or basins if hot water is placed on the floor. They may also be caused by children pulling over themselves vessels, saucepans or pans containing hot fluids or fat or by pulling the flexes of electric kettles.

Electric Blankets. The Fire Protection Association reports that, in the year ended June 1962, more than 7,000 fires were caused by electric blankets. They injured 61 people, two of whom died.

Most of the victims slept with the blanket switched on.

In spite of the fact that instructions are issued not to fold electric blankets, folding of blankets is given as the main cause of fires. The resultant creasing of the heating element can cause a short circuit or broken element.

The survey says fires have risen out of proportion to the number of blankets in use. They have risen from 11.6 per 10,000 in 1950, when 556,000 were estimated to be in use, to 13.7 per 10,000 in 1961-62, when the estimate in use was 5,557,000.

Burns and Scalds.

The Registrar General records that, during the year, 106 children aged 1-14 years lost their lives in their homes from this cause.

Deaths due to Burns and Scalds in England and Wales.

(From the Registrar General's Quarterly Returns)

	1962		1961	
	<u>Male</u>	<u>Female</u>	<u>Male</u>	<u>Female</u>
1st Quarter	25	31	10	26
2nd Quarter	7	18	8	11
3rd Quarter	9	7	11	9
4th Quarter	18	35	14	17
TOTAL	59	91	43	63

The Chief Medical Officer to the Ministry of Education reports:-

"Deaths in girls exceeded those in boys, and this is the only important category in which this reversal is found.

Although girls are more likely to be helping with cooking than boys, the most obvious cause is the difference in design and texture of girls' clothes. Day clothes are not so close-fitting, and the hem of a skirt can easily come into contact with an unguarded fire. The same can be said of night clothes as long as night dresses are preferred to pyjamas for girls.

Where the accident is not fatal, a child may sustain varying degrees of physical injury or of emotional damage and aesthetic defects may persist".

Preventive Measures

The majority of these burning and scalding accidents could be avoided, and, in spite of the publicity that has been given to the subject during recent years, the position has not MUCH improved.

While propaganda of all kinds plays a valuable part in prevention, it is the personal contact of doctors, nurses and social workers with the people in their homes that is likely to bring the most rewarding results.

Efficient Fireguards

The most effective simple way of reducing the number of serious burning accidents is by the use of the properly designed and fixed fire-guard of the British Standard Specification. It forms a protection from burning or falling into an open fire, by children tampering with one, or by clothing accidentally brushing against a fire.

Safer Clothing

The most frequent cause of serious burns is clothing catching alight. The provision of fireguards for all types of fires and the choice of safer garments for women and children to wear will reduce these accidents. The flammable nature of nearly all fabrics currently in use makes the guarding of fires doubly important. Pyjamas are much safer than nightdresses, particularly for children. Full skirted party dresses and other loose flimsy garments also require special caution.

It is now possible to buy children's clothing made of flame resistant material; you can also buy materials to make up yourself. It may be slightly more expensive, but surely it is worth spending about two shillings a yard more to prevent serious burns to young children.

Prevention of Scalding Accidents

Although in some cases, scalding accidents may be precipitated by the shape, design and use of the kitchen or by the form of domestic equipment, it is nevertheless clear that the majority of incidents are due to carelessness.

While the final responsibility for the prevention of burns and scalds in the home must rest with the householders, every authority, organisation and individual has something to contribute to the provision of safety in the home and it is only by the combined efforts of everyone that the incidence of burns and scalds can be reduced.

A C C I D E N T S (ON THE ROAD)

For the first time since 1952, road casualties in Britain fell by 2% with 199 fewer deaths. The decrease was mainly due to a reduction in motor-cycle and pedal cycle casualties.

67% of deaths on the road were the result of head injuries.

(a) Motor Cycles

Motor cycle casualties fell by 12% and pedal cycles casualties by 9% compared with 1961, but it may well be that many more people are taking to cars in preference to the seemingly more vulnerable motor-cycle.

90% of motor cyclists' deaths were from head injuries

Injuries to Motor-cyclists

	Killed	Serious	Slight
1954	1,148	15,847	35,536
1961	1,544	26,085	67,673
1962	1,323	24,256	61,034

It will be noted from the above table that the rate of increase in the number of deaths in 1961 compared with 1954 was considerably less than that of injuries. The reason for this lower rate of deaths may be because

many more people were wearing safety helmets in 1961 and were therefore injured and not killed.

There was a pleasing reduction in all three categories of casualties during 1962; but the level is still very much higher than in 1954.

I am indebted to the Royal Society for the Prevention of Accidents for the figures of casualties to riders and passengers of motor cycles and mopeds in Great Britain.

The Road Research Laboratory has revealed that the wearing of a safety helmet reduces by 30% to 40% the risk of head injury.

A man on a motor cycle is about 18 times more likely to be injured than a man inside a car; and the damage is far greater.

(b) Motor Cars

The number of deaths and seriously injured in cars increased by 4%.

Casualties among users of goods vehicles rose by 9%.

Car Seat-Belts

A recent report* on an analysis of the injuries sustained by car occupants, by two members of the Road Research Laboratory, gives details of 600 car accidents in which 837 drivers or front seat passengers were wearing seat-belts.

The following is an extract from the article:-

"The seat belts were of types approved by the British Standards Institution.

For purposes of comparison, the seat belts of different makes can be divided into four types:-

The full harness, the lap and diagonal with pillar fitting, the lap and diagonal with floor fitting and the diagonal only.

No fatalities are included and there are indications that slight accidents are not fully represented; but there is no reason to suppose that these defects affect the comparisons made.

All types of seat-belt were effective in reducing injuries to the user: when the seat-belts were worn, the percentage not injured was 66%; whereas, in the sample in which either the belt was not worn or there was no belt available, the percentage of persons not injured was only 32%.

*"The Practitioner" September 1963 Vol. 191.
by R. D. Lister and Barbara M. Milson.

The percentage of persons not injured while wearing a seat-belt was about the same for each of the different types of seat-belt, but there were slight differences in the pattern of the injuries:-

Where the diagonal belt was worn, injuries to the head and neck were slightly less than for the other types of belt, but injuries to the chest were slightly greater.

A single diagonal belt, which has one anchorage on the door pillar and one on the floor, usually provides more restraint for the upper part of the body than belts that have all-floor anchorage points. Injuries involving the head are therefore less likely with the single diagonal belt, but slight chest injuries are more likely.

Although the numbers are small, the lap and diagonal belt with a pillar fitting gives rise to a smaller proportion of serious injuries than the lap and diagonal with floor fitting.

The percentage of injuries to the legs and feet was practically the same for all types of seat-belt and was only slightly greater when either no belt was worn or there was no belt available, since the legs and feet are relatively unrestrained in each case.

The overall reduction in injuries through wearing the belt was 51%. Serious injuries were reduced by about 80%.

This Survey shows that, in August 1962, about 7% of cars studied were fitted with seat-belts. Thus, in spite of the considerable benefits to be derived from their use, seat-belts are still not widely fitted and worn."

A C C I D E N T S

(IN THE WATER)

During 1962, there were 690 deaths from drowning in Great Britain:- 79% were males, nearly one third were children under fifteen; and one in five was aged sixty-five or over.

In an excellent report on "Drowning", Dr. C. A. Boucher of the Ministry of Health has emphasised the following important facts:-

"It is maintained that inland water - particularly rivers, canals and quarries - constitute a greater danger, especially to children, than

coastal waters. The Coastguard Section of the Ministry of Transport reported small-boat and bathing incidents in 1961 in which 736 persons were involved and 90 were drowned".

The case histories of the Royal Humane Society suggest that non-swimmers are usually the victims and make it clear that panic is the greatest danger to survival.

In a survey of entrants into the Royal Navy, recruits to the Army and students in training colleges, two thirds were unable to swim. At the same time, two out of three children who left school were also found to be unable to swim.

PREVENTION: Prevention of drowning accidents depends on education stressing the dangers of water, particularly of deep or swiftly flowing water. Water safety should be as widely taught to children as road safety. Parents should encourage their children to learn to swim.

The Headmaster of Petersfield County Secondary School states that only 34 children attending his School could swim one length at the commencement of Summer Term 1962. At the end of the term, 120 children could swim that distance.

Equally important is the fact that a far greater number of children had learnt to swim a few strokes.

The Royal Society for the Prevention of Accidents has published a Water Safety Code and, for those who sail, a booklet entitled "Safety Afloat".

According to "WHICH" -

"A good life-jacket will not only keep you up, with your face and nose clear of the water; it will turn you over, within a few seconds, into the safest position - that is, on to your back and leaning back at an angle of roughly 45° , your feet down in the water, your face well out of it....."

This position - at 45° to the surface of the water - tends to prevent the head from falling forwards and is a good compromise between the vertical and horizontal. In a vertical position, waves will cause periodical immersion of the head and possibly sea sickness; while, in an horizontal position, the tongue may block the throat.

According to British Standards Institution:- "any life jacket made to B S 3595 and bearing the kite-mark will be of a very high standard indeed. We hope that, by next spring (1964), several kite-marked jackets will be on the market, and that yachtsmen will equip themselves only with these approved models".

The First Aid Supplement on Emergency Resuscitation has recently been published by the St. John Ambulance Association, the British Red Cross Society and the St. Andrews Ambulance Association.

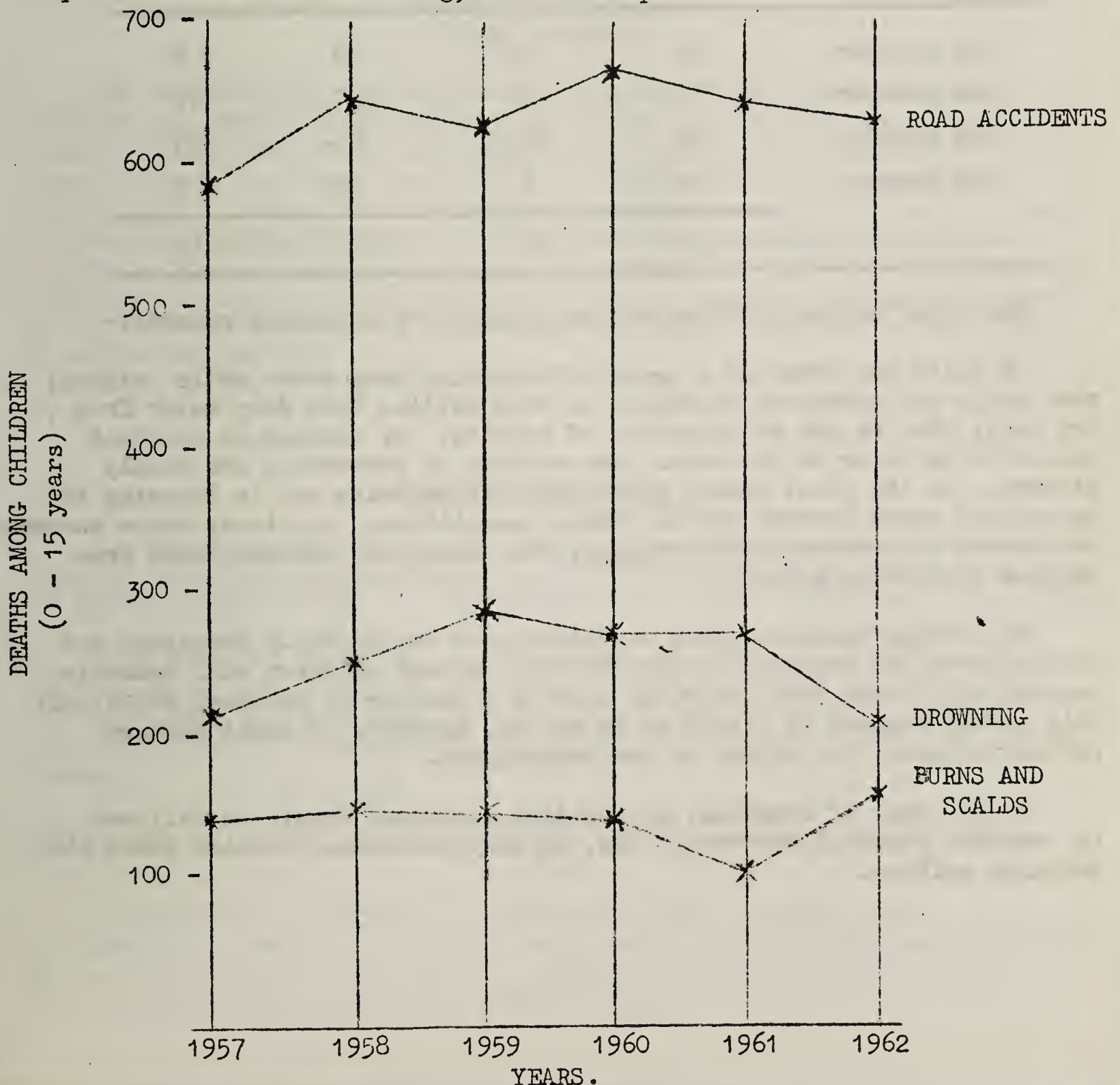
A C C I D E N T S
(CHILDHOOD DEATHS)

Accidental deaths in childhood (0-15 years) account for 39% of all deaths in this age group and also for more deaths than any single disease.

They must be attributed mainly to inadequate supervision; but carelessness, thoughtlessness, apathy and lack of knowledge of the adults in charge, all play their part.

The greatest effort in prevention is needed against road accidents, burns and scalds and drowning.

The following record of the number of child deaths over the last six years emphasises the need for far more vigilance on the part of those responsible for their training, care and supervision.



DROWNING.

During the year, 200 children lost their lives as a result of drowning.

Drowning can occur at home, but this is usually in infants in the first year of life, in the bath; it is quite a different problem from drowning outside the home.

Deaths due to Drowning in England and Wales 1962 and 1961.

	1962		1961	
	Male	Female	Male	Female
1st Quarter	35	3	38	8
2nd Quarter	57	8	67	11
3rd Quarter	65	10	86	23
4th Quarter	20	2	18	3
	177	23	209	45

The Chief Medical Officer of the Ministry of Education reports:-

"A child may drown as a result of entering deep water while bathing; when he is an inadequate swimmer; or from falling into deep water from dry land, when he had no intention of bathing; or through an accident whilst he is in or on the water, the methods of prevention are widely diverse. In the first group, proficiency of swimming and in learning to appreciate water hazards should reduce casualties. In places where currents are strong or beaches shelve rapidly, the inadequate swimmer needs protection by warning notices.

On bathing-beaches, where conditions are occasionally dangerous and beach-guards are provided to warn bathers, school children will commonly respond as if they were under the care of a teacher of physical education. This safety measure is likely to be wasted, however, if adult bathers refuse to accept the advice of the beach-guard.

In the case of drowning, an accident is either fatal, or followed by complete physical recovery; and, in many instances, skilled first aid measures suffice.

PETERSFIELD FURTHER EDUCATION CENTRE

I am indebted to Mr. E. C. Young for the following report on the Petersfield Further Education Centre:-

Judo Classes commenced in 1962 and instruction was given by Captain Weir. The classess were enthusiastically attended by adults (men and women) and also by youth groups (boys and girls).

Good progress was achieved and the instruction will be continued in 1963-64.

A C C I D E N T S

(OLD PEOPLE)

The accident rate is high in old people. With increase in age, physical and mental deterioration may reduce the capacity to co-ordinate thought and action. Some old people become fatigued, forgetful or absent minded, and these psychological features may be accompanied by physiological changes, failing vision, impaired hearing and sense of smell and muscular weakness; and the infirm and the handicapped are liable to accidents through inexpert handling of heating and lighting appliances and inability to avoid obvious hazards. Falls account for nearly two-thirds of fatal home accidents and nine-tenths of these fatalities affect people of sixty-five and over.

OLD PEOPLE'S WELFARE

In this Area, the Old People's Home, under the control of the County Council, which provide accommodation for about fifty-eight old people from all parts of the county, is Coldharbour Wood, Rake, (Telephone: Liss 2326).

I am indebted to Mr. F. J. Bryan Long, County Welfare Officer, for the following information on the County Council's Scheme for permanent and short stay accommodation in Old People's Homes, and for placing elderly people in private households under the County Council's Placement Scheme.

Admissions to Old People's Homes during the year ended 31st December, 1962.

Altogether 247 persons were admitted during the year, this represented a turnover of 28.8% of the average total of 857 beds provided in the County Old People's Homes. Included in these admissions were 85 or 34.4% of the total direct from hospital.

Provision of Short Stay Accommodation in Old People's Homes.

The Welfare-Committee of the County Council operate a scheme whereby any places temporarily vacant in the County Homes for old people are made available to elderly persons to enable the relatives or friends with whom they live to take a holiday.

Such temporary vacancies arise when residents are in hospital or away on holiday and when a new resident needs time to clear up his affairs. Some use is also made of sick bays during the summer months when there is less demand for nursing care.

The scheme enables people, who normally look after aged relatives, to obtain temporary relief from responsibilities they have undertaken whilst they go on holiday or occasionally when they themselves are ill.

During the year 1962, altogether 128 old people were admitted to Old People's Homes under the scheme, in addition to 247 permanent admissions. In this district (Petersfield) there were 12 admissions (including 5 temporary admissions) to Old People's Homes. In addition 159 visits were paid to aged and infirm and handicapped persons.

Accommodation under this scheme cannot be offered to old people needing regular medical and nursing care; generally they should be able to wash and dress themselves, get to the dining room for meals and attend to their own toilet.

Applications for short stay admission may be made either to the local Area Welfare Office or direct to the County Welfare Officer at The Castle, Winchester.

County Placement Scheme.

The Welfare Department first began a "home finding" scheme in 1952. It is a scheme for placing elderly people, who are active enough not to need constant care and attention, in suitable private accommodation and it is proving very successful in maintaining the independence of old people and in finding suitable accommodation for them.

There are many old people today living alone who may have accommodation which they would be glad to share with an elderly person, and whose companionship would enable them to live a fuller life and offset loneliness.

No average charge figure is available. Terms are negotiated separately in each case in the light of the standard of accommodation and services offered, the financial resources of the applicant and any other relevant factors.

Foster homes are found through press advertisements and contacts through voluntary and statutory bodies.

Foster homes are found mainly on a short stay basis, but considerable numbers of people are permanently boarded. Some old people often share a home with another. Alternative action to boarding out is considered when applications are made. Visiting is done by County Welfare Officers. A geriatric social worker has been appointed to co-ordinate and develop the Placement Scheme and to specialise to a greater degree in bringing together people with similar interests. It is also intended to make follow up friendly visits to give advice and practical assistance to assure them that somebody is available to help them solve their problems.

Chiropody Service.

Very good Chiropody services have been established for old people by the British Red Cross Society, the Hampshire Council for Social Service and the numerous local Old People's Welfare Committees.

The Minister of Health has suggested that, at this stage, priority should be given to the elderly, the physically handicapped and expectant mothers, and that Local Health Authorities might wish to develop their Schemes by using existing voluntary services.

The Hampshire County Council will make grants to both the British Red Cross Society and the Hampshire Council of Social Service; and the latter will make small grants to the various Local Old People's Welfare Committees.

Further development of the Chiropody Service in relation to the physically handicapped and expectant mothers will be dealt with through the British Red Cross Society.

Marie Curie Memorial Foundation.

The above Foundation operates a scheme whereby help can be given to meet the urgent needs of necessitous cancer patients being nursed at home.

The County Medical Officer has been appointed as agent for the County Scheme which will provide these patients with help 'in kind' (e.g. linen, bedding, laundry necessities, special equipment for the comfort of the patient etc.).

INTERNATIONAL TRAVEL

Travellers from abroad, who may have been contacts of smallpox or other dangerous diseases while out of this country, are required to show their doctors notices issued to them on arrival at airports in the event of their becoming ill during the succeeding twenty-one days.

Passengers undertaking international travel must be in possession of certain vaccination certificates, depending upon the place of departure, the countries of transit and the destination. International certificates are issued in connection with smallpox, yellow fever and cholera.

All persons travelling from any place in Asia, Africa or the Americas, (excluding Canada and the U.S.A.) or from any smallpox - infected local area wherever it may be, are now required to produce a valid International Certificate of Vaccination against smallpox on arrival in the country.

The International Sanitary Regulations, 1956, specify the following periods for the validity of International Certificates of Vaccination:-

<u>Type of Vaccination</u>	<u>Validity (after date of Vaccination or inoculations)</u>	
	<u>Begins</u>	<u>Ends</u>
Smallpox - primary vaccination	8 days	3 years
Smallpox - re-vaccination	At once	3 years
Cholera - primary vaccination	6 days	6 months
Cholera - re-vaccination within six months	At once	6 months
Yellow Fever - primary vaccination	10 days	6 years
Yellow Fever - re-vaccination within six years	At once	6 years

Smallpox vaccination within the previous three years is required before entry into many countries.

Yellow fever inoculation during the preceding six years is required before entering or passing through regions of Central and South America or Africa, designated as "Yellow Fever Receptive Areas".

For travel into or through countries where cholera is endemic (India, Pakistan, Burma, etc.) immunisation against cholera within the preceding six months may be required. But the health authorities of some countries vary these periods and details of immunisation requirements can be obtained from the airline or steamship company concerned, or from the Consulates of the countries to be visited.

Persons, who are required to be vaccinated or inoculated against more than one disease, are advised to tell the doctor of all the vaccinations or inoculations needed as they may have to be done in a particular order with certain minimum intervals.

The vaccinations against smallpox and cholera must be recorded on the international certificate form prescribed by the World Health Organisation, dated and signed by the doctor doing the inoculations, authenticated and stamped at the office by the Health Department of the District.

The international certificate forms for smallpox and cholera vaccinations must be obtained (by the traveller himself) from the travel agency or Ministry of Health; those for yellow fever are obtained at certain recognised centres where the vaccination is performed.

In this area, yellow fever vaccinations are carried out at the Health Centre, Kings Park Road, Southampton, once a week (on Wednesdays) and the traveller is advised to make an appointment by telephone - Southampton 23788.

SMALLPOX VACCINATION

The speed of air travel makes the task of preventing the imported case of smallpox particularly difficult; so the earliest possible detection of the disease is of the utmost importance in preventing the spread.

Outbreaks of smallpox in this country generally arise from the importation of the disease from abroad; smallpox may be introduced into this Country in an insidious way through the entry of persons in apparent good health, but in whom smallpox is incubating.

In such circumstances, the disease - modified by vaccination - has often gone unrecognised until it has appeared in classical form in others exposed to infection.

For the period - December 1961 to April 1962 - there were no less than five separate importations of smallpox to this Country, from Karachi where a considerable epidemic existed from November 1961 to February 1962. At the same time, large numbers of Pakistani immigrants were travelling here by charter flight and at minimal fares.

In these outbreaks, there was a total of 67 cases with 26 deaths giving a fatality rate of 39% - some indication of the lethal nature of smallpox, a disease for which there is no specific treatment.

The basis of smallpox control is to isolate the case, seek out and vaccinate all contacts, and keep them under effective surveillance.

Indiscriminate mass vaccination has seldom any value in the control of a smallpox outbreak. While it may be difficult for the public at large to resist the temptation to ask for vaccination whenever an epidemic threatens, it must be appreciated that any demand for wholesale vaccination will only result in diverting the medical manpower from its main line of attack - namely, the tracing, vaccination and surveillance of contacts. In an emergency, available lymph should be used for the vaccination of contacts (who should receive first priority), of babies, and of travellers abroad.

There is no evidence to justify the suggestion that outbreak control alone would necessarily prove effective in an unvaccinated population; so routine vaccination should continue in early childhood.

For some years, the low acceptance rate and the resulting lack of protection to the individual and the community has caused much concern; the aim should be to see that every healthy infant is vaccinated - not only because routine vaccination in early life is thought to be justified as the first step in establishing a satisfactory immunity in later years, but also on account of the immediate protection thereby conferred, and the occurrence of outbreaks of imported smallpox from time to time only confirms that the extent of immunity against this disease is not sufficient to prevent an epidemic.

Vaccination protects the individual from smallpox in most instances for several years and can be expected to modify the severity of the disease and reduce the risk of death for a much longer period.

The Ministry of Health recommends routine primary vaccination in the first two years (preferably in the second year) for all infants except the few in whom the well-defined contraindications to routine vaccination exist.

The importance of primary vaccination as a routine is that the anti-body response to revaccination, when persons are placed at risk, is likely to be more rapid and to reach a higher level than can be attained by primary vaccination. In other words, the boosting stimulus of re-vaccination will ensure a rapid and high level of immunity to smallpox infection.

If the first vaccination is put off until adolescence or later, there may be a slight risk; and, since many persons will need to be vaccinated at some time, it is highly desirable that this should be done in early life -

if only as an insurance against possible untoward effects of vaccination later on.

Smallpox is no longer endemic in Europe and the chance of the individual stay-at-home Englishman ever encountering it may be remote, but not everyone remains at home and vaccination is often a pre-requisite for travel or for entry into many countries, as well as an essential for persons' protection in those areas in which smallpox is endemic. It is necessary in certain types of employment within this country and obligatory for service with the Armed Forces.

So, the probability is that for one reason or another a substantial number of residents in this country will find it desirable to be vaccinated on some occasion during their lives.

The susceptibility of the community as a whole to epidemic smallpox of either the mild or the severe variety cannot be greatly diminished by routine infant vaccination alone. To guard against the social disruption and economic loss which invariably results from the rapid spread of any form of smallpox, it is necessary for the re-vaccination of school children as well as vaccination of infants to be done as a routine.

The re-vaccination of children between the ages of eight and twelve years not only maintains or revives their individual protection, but is likely to facilitate substantially the control of local out-breaks of smallpox. It also ensures that any further vaccination in later life will be less likely to have any serious reactions or complications.

Re-vaccination, carried out at school age, is practically trouble free; and this procedure, done as a routine at least once on all children primarily vaccinated in infancy, would substantially diminish the chance of rapid spread of smallpox. So it is hardly surprising that the Ministry is now strongly urging that re-vaccination of school children should be encouraged.

It is unfortunately something of a paradox that the application of preventative measures, so easily and fully available, should in a great many instances have to await the occurrence of the very condition they are designed to prevent before advantage is taken of them.

During the year, 1,061 vaccinations against smallpox were carried out:-

VACCINATION	Pre-school Children	School Children	Over 15 years of age
Primary	114	48	115
Re-vaccination	17	268	499
TOTAL	131	316	614

WHOOPING COUGH IMMUNISATION

At the beginning of 1955, the Hampshire County Council's Scheme for Whooping Cough immunisation began operating throughout the whole of Hampshire.

The scheme includes combined immunisations against whooping cough and diphtheria, and triple immunisation against whooping cough, diphtheria and tetanus; it also provides for immunisation against whooping cough alone under the age of five years.

Combined whooping cough and diphtheria immunisation with or without tetanus is often preferred for the primary immunisation of young children, so as to reduce the total number of inoculations needed for immunisations against three infections.

Whooping cough immunisation is generally advised early - at about the third or fourth month.

During the year, 131 immunisations against whooping cough were carried out.

POLIOMYELITIS VACCINATION

In May 1956, the County Council's scheme for poliomyelitis vaccination of children, born in the years 1947-54, began in selected areas of Hampshire. The age limit was extended in 1957 and 1958, and by 1959, the age group for registration was raised to twenty-six and the vaccinations were carried out as supplies of vaccine became available.

In February 1960, it was further extended to include persons up to the age of forty years of age.

In April 1961, arrangements were made for fourth injections of Salk vaccine to be offered to children between five and twelve years of age.

In February 1962, oral vaccine was made available for the routine immunisation of special groups as an alternative to the inactivated Salk vaccine.

During the year, 502 vaccinations against poliomyelitis were carried out.

SALK VACCINE			
Age	Primary	Booster	Fourth Injection
Under 1 year	21	2	-
1 - 4 years	8	52	3
5 - 14 years	1	24	48
Over 15 years	14	96	1
40 + (and special risk groups)	9	-	1
TOTALS	53	174	53

ORAL VACCINE			
Age	3 Doses	Re-inforcing Doses After 2 of Salk	Re-inforcing Doses After 3 of Salk
Under 1 year	36	1	-
1 - 4 years	24	40	3
5 - 14 years	5	9	34
Over 15 years	11	50	3
40 + (and special risk groups)	6	-	-
TOTALS	82	100	40

The success of this scheme is due not only to the general practitioners, who have given practically all the inoculations, but also to the parents who have so wisely seized the golden opportunity.

Personal Precautions against Poliomyelitis

The World Health Organisation has issued six points for the personal protection of the public against Poliomyelitis.

The six rules for the individual to observe are as follows:-

1. Wash hands frequently, especially before eating.

2. Protect food from flies; thoroughly wash Uncooked food, such as fruit and vegetables.
3. Avoid intimate association, such as shaking hands with families in which poliomyelitis has occurred within three weeks.
4. Treat feverish illnesses with caution; bed rest, or at least avoiding over-exertion for a week is advisable.
5. Avoid over-exertion.
6. Avoid unnecessary travel to and from communities where the disease is prevalent.

DIPHTHERIA IMMUNISATION

The following information has been based on reports from the Ministry of Health and Registrar General and on pamphlets issued by the Central Council for Health Education.

England and Wales	1957	1958	1959	1960	1961	1962
Cases	37	80	102	53	52	16
Deaths	4	8	-	5	10	2

It will be noted from the above table that the incidence of diphtheria has fallen considerably since 1959; in fact, this is the lowest figure recorded since the introduction of compulsory notification of this disease. But two of the sixteen cases died - a fatality ratio of 12.5 - which underlines the substantial risk of death to those who become ill with diphtheria.

It will be seen that there was also a rise in mortality in 1961. All these facts remind us that this disease is still a "Killer" and could again become a serious menace.

During 1962, the only outbreak was in Glamorgan, where cases occurred. The difficulty created by such an outbreak is illustrated by the fact that 147 "carriers" were discovered during the investigation in Glamorgan. These were admitted to hospital and treated to eliminate their carrier state.

None of the confirmed cases of diphtheria in 1962 had been effectively immunised against that infection; indeed, only three had had any anti-diphtheritic inoculation at all.

For some years; attention has been drawn to the serious position that would arise if a high level of immunisation of children is not reached and, thereafter, maintained.

Before the nation wide Immunisation Campaign was started in 1943, the average incidence was 50,000 a year. The scheme quickly got under way and resulted in a steady drop in the number of cases until 1958. Although complete eradication of the disease from an area where cases occur endemically is not an easy matter, there is evidence that there are good prospects for maintaining freedom - once it has been gained - if only immunisation is generally accepted.

Experience over the last few years has shown that in school communities where immunisation rates are low, diphtheria infection, when once introduced, can gain momentum and lead to an outbreak. The need for early immunisation and for booster doses is therefore stressed.

A more complete protection in the under 5 age group would soon cause reduced incidence in the early school (5-9) age group and the disease might well be almost eliminated. Only if an adequate level of immunisation is maintained, can diphtheria be driven altogether from this country.

The great majority of parents nowadays have never known or heard of a case of diphtheria among local children and are more afraid of illnesses they know; but, if they leave their children unprotected, they may gain knowledge of this disease from personal experience.

Complacency, resulting from what has already been achieved, or loss of interest in immunisation, may mean that diphtheria will go on occurring endemically and epidemically in this country indefinitely, with the ever-present risk of a return of high mortality; but a vigorously continued immunisation programme, combined with existing methods of epidemic control, may free us entirely from the disease - except for the occasionally imported case.

Authorities recommend that all children should be immunised before their first birthday and should receive a booster or re-inforcing dose just before entering school, and again when they are about ten years old. If immunisation is carried out before the age of six months, an extra booster is advised at fifteen to eighteen months.

Immunity against diphtheria takes several weeks to develop; but a booster, given to those who have been inoculated earlier in life, will produce rapid protection.

It is, therefore, of the utmost importance for parents to realize that active immunisation in the first year of life and re-inforcing doses of prophylactic in later years are just as necessary in the absence of diphtheria epidemics as in their presence.

The Ministry of Health reports that the percentage of children in England and Wales, who may be regarded as "remaining protected against diphtheria" during the past two years, are as follows:-

Age Groups	1961	1962
Under 5 years	64%	65%
Under 15 years	51%	54%

In this District, 77.5% of the children born during the year 1961 were immunised before they attained the age of one year.

Children up to five years of age are the most susceptible; but all school children should be immunised.

During the year, 159 immunisations against diphtheria were carried out:-

Immunisations	Pre-School Children	School Children
Diphtheria - Primary	-	-
Diphtheria - Re-inforcing or "Booster"	-	5
Whooping Cough alone	-	-
Diphtheria/Tetanus combined - Primary	-	-
Diphtheria/Tetanus combined "Booster"	-	3
Triple - Primary	101	2
Triple - "Booster"	2	26
TOTALS	103	36

Children may be immunised by their own doctors or at a Child Welfare Centre.

NOTIFIABLE DISEASES.

Particulars of cases of infectious diseases that occurred during the course of the year are shown in the following table.

DISEASES	Total Cases Notified		Total Deaths	
	M.	F.	M.	F.
Meningococcal Meningitis	-	1	-	-
Scarlet Fever	-	1	-	-
Diphtheria	-	-	-	-
Puerperal Pyrexia	-	-	-	-
Pneumonia	2	-	-	-
Dysentery	-	-	-	-
Erysipelas	-	-	-	-
Ophthalmia Neonatorum	-	-	-	-
Enteric Fever (including Paratyphoid)	-	-	-	-
Acute-Poliomyelitis & Polio-encephalitis	-	-	-	-
Cerebro-spinal Fever	-	-	-	-
Measles	3	3	-	-
Whooping Cough	-	-	-	-
TOTAL	5	5	-	-

An analysis of the total notified cases according to age groups is given below:-

Age Group	Pneumonia		Measles		Meningococcal Meningitis		Scarlet Fever	
	M.	F.	M.	F.	M.	F.	M.	F.
Under 1 year	-	-	-	-	-	-	-	-
1 year	-	-	1	-	-	-	-	-
2 years	-	-	-	1	-	-	-	-
3 years	-	-	-	-	-	-	-	-
4 years	-	-	-	1	-	-	-	-
5 to 9 years	1	-	2	1	-	1	-	1
10 to 14 years	-	-	-	-	-	-	-	-
15 to 24 years	-	-	-	-	-	-	-	-
25 years and over	1	-	-	-	-	-	-	-
Age unknown	-	-	-	-	-	-	-	-
Total all ages	2	-	3	3	-	1	-	1

Only certain forms of pneumonia are notifiable. No deaths from infectious diseases occurred.

TUBERCULOSIS

Age Group	New Cases (Including Transfers)				Removed from Register			
	Respiratory		Non-Respiratory		Respiratory		Non-Respiratory	
	M.	F.	M.	F.	M.	F.	M.	F.
0 - 1	-	-	-	-	-	-	-	-
1 - 5	-	-	-	-	-	-	-	-
5 - 15	-	-	-	-	-	-	-	-
15 - 25	-	-	-	-	-	-	-	-
25 - 35	-	-	-	-	-	1	-	-
35 - 45	1	1	-	-	1	-	-	-
45 - 55	-	1	-	-	1	-	-	-
55 - 65	-	-	-	-	-	-	-	-
65 and Over	-	-	-	-	-	-	-	-
Total all ages	1	2	-	-	2	1	-	-

On 31st December, 1962, the total number of Tuberculosis cases on the register was seventy nine.

SCABIES.

Facilities for the treatment of scabies are available at Portsmouth Disinfestation Clinic.

Appointments for cases requiring treatment are made through this Department.

Scabies should be regarded as a family infection and all members of the same family should present themselves for treatment simultaneously whether or not they complain of "The Itch" and show evidence of scabies at the time; otherwise an early case may escape detection and the parasite may thrive in one member and re-infect the others.

PEDICULOSIS.

Where necessary, cases of pediculosis (head lice) may be referred for treatment at the County Health Centre, Love Lane, Petersfield, by special appointment.

Pediculosis should also be regarded as a family infection and, when a child is found to be verminous, all the members of the family should offer themselves for examination. This wise practice would ensure that any undetected case in the same family would receive immediate treatment and that there would be no further spread of infection to others.

NATIONAL ASSISTANCE ACT.

During the year no official action was taken under Section 47 of the National Assistance Act, 1948, in connection with the removal to hospital of persons "who are suffering from grave chronic disease or, being aged and infirm or physically incapacitated, are living in insanitary conditions and are unable to devote to themselves, and are not receiving from other persons proper care and attention".

No potential case was brought to the notice of this department.

CITIZENS' ADVICE BUREAU.

The local Office of the Citizens' Advice Bureau, which is under the auspices of the National Council of Social Service, is in the Town Hall Annexe (Telephone, Petersfield 749) at the rear of the Town Hall. This office is open Monday to Friday from 9 a.m. to 12.30 p.m. and from 2 p.m. to 4.00 p.m. On Saturday it is open from 9 a.m. to 12.00 p.m.

REPORT ON THE WORK OF THE PUBLIC HEALTH INSPECTOR
for the year ended 31st December, 1962.

WATER SUPPLY

On 1st April 1960, the Council sold the Water Undertaking to the Wey Valley Water Company, Farnham.

The chief source of supply remains at the two deep boreholes situated at Sheet, augmented by spring water from Oakshott.

The two sources of supply were sufficient to meet requirements. These supplies are chlorinated and samples are regularly sent for analysis.

All the houses in the district are supplied direct from the Company's main, with the exception of four houses supplied from wells.

WATER SAMPLES

	<u>Number of</u> <u>Samples.</u>	<u>Satisfactory.</u>	<u>Fairly</u> <u>Satisfactory.</u>	<u>Unsatisfactory.</u>
Main Water	41	40	-	1
Private Supply	1	1	-	-
Swimming Bath Water -				
Petersfield Bath	28	22	4	2**
Churchers College	4	2	2	-
Private Bath	1	1	-	-

** Chlorinator not working.

At the Petersfield Swimming Bath, all samples taken after the middle of June were satisfactory. In the early period, the correct dosage of chlorination had to be ascertained.

DRAINAGE AND SEWERAGE

The sewage works is now working beyond the capacity for which it was designed. The Council are to consider the extension of the works to meet present and future demands.

Houses which drain to cesspools can have these emptied twice a year without charge, on application to the Health Department.

Houses which have pail privies have these emptied twice weekly by the Southern Cleansing Service. These houses are mainly situated at Stroud, where there is no sewer, and the service worked satisfactorily during the year.

PUBLIC CLEANSING

The Council is responsible for the cleansing of all roads in the district.

Refuse collection is carried out weekly.

These services are the responsibility of the Surveyor's Department.

SHOPS

Shops are inspected for compliance with the Shops Act, mainly when visiting the premises under other Statutes.

INSECT INFESTATION

No case of infestation by bed bugs was reported, but several complaints of flea and cockroach infestation were received; advice was given in these cases.

One case of fly infestation in the roof of a house was reported, but it was only a very slight infestation and easily dealt with.

REFUSE TIPS

The refuse tip in The Causeway was used early in the year; but, for the greater part of the year, tipping was carried out on land adjoining the Sewage Works, which is well away from any houses.

CAMPING SITES

The new site, for 25 caravans, continues to operate in Durford Road. The conditions conform with the requirements of the Caravan Site and Control of Development Act, 1960.

The site in the Causeway is now licensed for 150 caravans, and an extra block of sanitary conveniences has been constructed. The Owner has been given a period of several years to enable him to comply with all the requirements of the Act. Work is progressing steadily to bring the site up to the full standard. Many of the caravans are now connected to the drainage system, and have a full water-carriage system of sanitation.

There are also several temporary sites for one or two caravans only. These have only limited planning permission.

GENERAL INSPECTION OF THE AREA

Total number of visits made (including food inspection)	-	2,401
Number of complaints received and dealt with	-	108

VISITS AND INSPECTIONS

Bakehouses	-	-	-	-	-	4
Butchers and Fishmongers	-	-	-	-	-	117
Cafes	-	-	-	-	-	77
Moveable Dwellings	-	-	-	-	-	66
Dairies (including sampling)	-	-	-	-	-	85
Drainage (including drain testing)	-	-	-	-	-	85
Factories	-	-	-	-	-	55
Fried Fish Shops	-	-	-	-	-	4
Grocers and Confectioners	-	-	-	-	-	130
Greengrocers	-	-	-	-	-	26
Housing (Public Health and Housing Acts)	-	-	-	-	-	148
Hotels	-	-	-	-	-	11
Infectious Disease	-	-	-	-	-	4
Market	-	-	-	-	-	132
Miscellaneous	-	-	-	-	-	148
New Buildings	-	-	-	-	-	114
Meat Inspection (Grange Slaughterhouse)	-	-	-	-	-	607
Privies and Cesspools	-	-	-	-	-	20
Rodent Control	-	-	-	-	-	452
Schools	-	-	-	-	-	10
Shops (Shops Act)	-	-	-	-	-	45
Water Supply (including sampling)	-	-	-	-	-	60

RODENT CONTROL

Complaints of infestation by rats were again relatively few in number, but survey work was carried out, mainly when visiting premises for other purposes.

Regular treatments were given to the Council's Refuse Tip and Sewage Works. Small infestations in the Council Yard and Sheet Institute were also dealt with.

A maintenance treatment of the sewers in The Causeway, Cranford Road Area and The Borough, was carried out in October, only very slight infestation was recorded.

The following table gives details of inspections and treatments for the year 1962.

	TYPE OF PROPERTY				<u>Total</u>
	Local Authority (except houses)	<u>Dwelling Houses</u>	<u>Business Premises</u>	<u>Agricul- -tural</u>	
1. Number of Properties in Local Authority's District	15	2,445	374	20	2,824
2. Number of Properties inspected as a result of :-					
(a) Notification	-	40	7	-	47
(b) Surveyed under the Act	6	40	20	4	90
(c) Otherwise (when visited primarily for some other purpose)	6	143	68	10	227
3. Total inspections carried out including re-inspections	100	235	95	22	452
4. Number of Properties inspected which were found to be infested by:					
(a) Rats (Major)	3	-	-	-	3
(Minor)	1	35	6	1	43
(b) Mice (Major)	-	-	-	-	-
(Minor)	-	4	-	-	4
5. Number of infested Properties treated by Local Authority	6	39	5	1	51
6. Number of notices served under Section 4 of the Act	NIL	NIL	NIL	NIL	NIL
7. Number of "Block" Control Schemes carried out	-	4	-	-	4

SUMMARY OF WORK CARRIED OUT UNDER
PUBLIC HEALTH AND HOUSING ACTS

1. Inspection of dwelling houses during the year :-

(1) (a) Total number of dwelling houses inspected for housing defects (under Public Health or Housing Acts)	-	-	-	80
(b) Number of inspections for the purpose	-	-	-	148

(2) (a) Number of dwelling houses (included under subheading (1) above, which were inspected and recorded under the Housing Consolidated Regulations, 1925	-	-	-	65
(b) Number of inspections made for the purpose	-	-	-	128

(3) Number of dwelling houses found to be in a state so dangerous or injurious to health as to be unfit for human habitation	-	-	-	2
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(4) Number of dwelling houses (exclusive of those referred to under the preceding sub-heading) found not to be, in all respects, reasonably fit for human habitation	-	-	-	23
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2. Remedy of defects during the year without service of formal notices :-

Number of defective dwelling houses rendered fit in consequence of informal action by the Local Authority or their Officers	-	-	-	18
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3. Action under Statutory Powers during the year :-

Proceeding under Sections 9, 10 and 12 of the Housing Act, 1957 :-

(1) Number of dwelling houses in respect of which notices were served requiring repairs	-	-	-	Nil
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Proceeding under Sections 16 & 17 of the Housing Act, 1957 :-

(1) Number of dwelling houses in respect of which demolition or closing orders were made	-	-	-	Nil
(2) Number of houses in respect of which an undertaking was received	-	-	-	Nil

4. Overcrowding :-

No cases of overcrowding were found during the year.

INSPECTION AND SUPERVISION OF FOODMILK

The Food and Drugs Act, 1944, which came into force on the 1st October, 1949, places the responsibility for the supervision of the retail dairies and distributors on Local Authorities.

Under the Milk (Special Designation) (Pasteurised and Sterilised) Regulations, 1960, the licensing of Pasteurising Plants and Tuberculin Tested Milk are the responsibility of Food and Drugs Authorities. The Hampshire County Council have delegated their functions to the Councils of County Districts.

There is one pasteurising plant in the district at a large wholesale depot, where conditions and supervision are satisfactory. This pasteurising plant is a High Temperature Short Time Plant, from which samples have been regularly taken over the last fourteen years without a failure.

Regular samples were again taken to check the sterilisation of milk bottles. Of 84 bottles tested, all were satisfactory.

Clean bottles are beneficial to all concerned, and there is less souring of milk. The average count per pint bottle of the satisfactory bottle samples was only 7, as the accepted standard is 600 per pint bottle, this reflects great credit on the dairymen concerned.

Details of Milk Producers and Dealers.

Number of Retail Purveyors	-	-	6
Wholesale Dealers	-	-	1
Licensed Retailers of Tuberculin Tested Milk			6
Licensed Producers of Pasteurised Milk	-		1
Licensed Retailers of Pasteurised Milk	-		6
Licensed Retailers of Sterilised Milk	-		4

Details of Sampling.

	<u>No. of Samples.</u>	<u>Passed Ring Test.</u>	<u>Passed Methylene Blue Test.</u>	<u>Passed Phosphatase Test.</u>	<u>M.B. Test not carried out temp. 70°F.</u>
Pasteurised Milk	23	-	23	23	-
T.T. Pasteurised	21	-	21	21	-
Tuberculin Tested	7	7	7	-	-

MILK BOTTLES

<u>No. of Samples.</u>	<u>Satisfactory.</u>	<u>Fairly Satisfactory.</u>	<u>Unsatisfactory.</u>
84	84	-	-

The average count per pint bottle of the satisfactory samples was 7.

The standard laid down by the Public Health Laboratory Service is :-

Mean Bottle Count reckoned as per pint bottle -

Not more than 600	- Satisfactory.
Over 600 but less than 2,000	- Fairly Satisfactory.
Over 2,000	- Unsatisfactory.

MEAT INSPECTION

The Petersfield Wholesale Meat Company Limited continued the wholesale meat business established on de-control of meat, facilities are available for local butchers to have food animals slaughtered.

The Company sell meat to a large area of Eastern Hampshire, Sussex and Surrey, including Portsmouth, Southampton, Winchester, Farnham, Guildford and Haslemere and even the Channel Isles, as well as the immediate neighbourhood of Petersfield.

The modernisation of the slaughterhouse was completed in 1959, and in 1960, the new construction Regulations came into force in this district.

During the year a large extension to the slaughterhouse was constructed to enable cattle and smaller animals to be slaughtered and dressed simultaneously.

Tribute must be made to Mr. Swan, Chief Public Health Inspector of the Petersfield Rural District Council and staff, who carried out meat inspection during a period of illness, and also during holidays.

The premises are well run and a good standard is being maintained.

One hundred per cent inspection of all carcasses and offal is being maintained, and it is very necessary as meat is sent to so many other districts. To maintain this standard of inspection means many evening visits, but, since the chill rooms were constructed, hardly any slaughtering is done on Sundays.

The number of animals slaughtered continues to increase, the total animals killed, 27,980 was 2,214 more than in 1961. This figure represents 13,760 cattle units.

Cysticercus Bovis - 12 cases of this disease were discovered during the year, all were singly cysts.

TUBERCULOSIS

One cow was found with generalised tuberculosis, this was notified to the Veterinary Office at the Ministry of Agriculture, Fisheries and Food, at Winchester, to enable them to check the origin. The case was confirmed after laboratory tests.

EMERGENCY SLAUGHTER

Animals can still be sent in by farmers for emergency slaughter at their own risk. Most of the condemned carcasses were of animals slaughtered in this way.

MEAT INSPECTED AND CONDEMNATIONS

Details of Inspections	Cattle Excluding Cows	Cows	Calves	Sheep and Lambs	Pigs
Number killed and inspected	3387	1311	1809	7590	13883
All diseases except Tuberculosis - whole carcasses condemned	1	7	32	6	35
Carcasses of which some part or organ was condemned	325	142	2	75	5799
Percentage of the number Inspected affected with disease other than Tuberculosis	9.62	11.36	1.88	1.07	42.02
Tuberculosis only whole carcasses condemned	-	1	-	-	-
Carcasses of which some part or organ was condemned	-	-	-	-	31
Percentage of the number inspected affected with Tuberculosis	-	.006	-	-	0.22

Total number of animals slaughtered 27,980

DISEASES IN FOOD ANIMALS - CATTLE

DISEASES	Whole Carcases all ofal	Hind Quarters	Fore Quarters	Other part carcases	Livers	Part Livers	Lungs	Heads and Tongues	Hearts	Spleens and Sirts	Tripes and Guts	Udders
Abscesses	No. lbs.	No. lbs.	No. lbs.	No. lbs.	No. lbs.	No. lbs.	No. lbs.	No. lbs.	No. lbs.	No. lbs.	No. lbs.	No. lbs.
Actinomycosis					117 1640		8 82	1 32			3 90	
Angioma					74 1040			5 158				
Bruising	1 598	1 40	1 40	1 30			1 12					
Oedema	1 478											
Cysticercus Bovis								12 396	12 132	12 25		
Distomatosis					228 3280	713 4310						
Fevered	1 526											
Gangrene	2 1060											
Inflammation					3 50				2 22	1 3	4 130	
Mastitis												12 260
Melanosis					1 15		2 23		1 7			
Pericarditis									6 62			
Pleurisy							8 84					
Septicaemia	2 1218											
Tuberculosis	1 626											
TOTALS	8 4794	1 40	1 40	1 30	423 6045	713 4310	19 201	18 586	21 223	13 28	7 220	12 260

DISEASES IN FOOD ANIMALS.

CALVES				SHEEP				PIGS					
DISEASES	Carcases	Heads	Plucks	Carcases	Carcases	Lungs	Livers	Carcases	Part Carcases inc. Heads	Plucks	Lungs	Livers	Guts
Abscesses	No. lbs. 1 58	No. lbs. 1 10	No. lbs. 1 8	No. lbs. 1 36	No. lbs. 1 72	No. lbs. 14 30	No. lbs. 2 210	No. lbs. 17 160	No. lbs. 20 280	No. lbs. 75 400	No. lbs. 3004 600	No. lbs. 492 1042	No. lbs. 120 2200
Bruising	1 27						4 310						
Cirrhosis													
Coryne Bacterium										75 400		492 1042	
Distomatosis									39 390				
Emaciation				1 36		5 11							
Erysipelas							3 170						
Fever Acute	4 198			2 110			4 480						
Inflammation							3 260						
Immature	10 163						3 240				3004 600		
Jaundice	4 160												
Joint Ill	7 210						1 80						
Multiple Tumours													
Moribund							2 130						
Oedema				1 56									
Parasitic Cysts				1 68									
Pneumonia					56 72	14 30							
Septicaemia	5 153						10 610				2001 400		
Swine Fever							3 210						
Tuberculosis									31 210				120 2200
TOTALS	22 969	1 10	1 8	6 610	56 72	19 41	25 2950	107 1040	75 400	5005 10200	492 1042	120 2200	

Food Premises.

The following table shows the number of different types of food premises in the District -

Butchers and Food Preparing Premises (Registered Sec. 14

Food and Drugs Act 1955)	-	-	-	-	5
Grocers -	-	-	-	-	19
Greengrocers	-	-	-	-	4
Fishmongers	-	-	-	-	2
Confectioners and Sweets	-	-	-	-	11
Food Hawkers	-	-	-	-	3
Cafes	-	-	-	-	11
Hotels serving meals	-	-	-	-	8
Other Hotels	-	-	-	-	8
School Canteens	-	-	-	-	4
Factory Canteens	-	-	-	-	2
Bakehouses	-	-	-	-	2
Fried Fish Shops	-	-	-	-	2
Slaughterhouse	-	-	-	-	1
Dairies	-	-	-	-	5
Clubs	-	-	-	-	3
Chemists	-	-	-	-	4
Ice Cream (Registered Premises, Sec.16)	-	-	-	-	
Sale of Ice Cream	-	-	-	-	20
Manufacture of Ice Cream	-	-	-	-	Nil

The following foodstuffs were voluntarily surrendered and condemned -

Sausage	-	30 lbs
Pears	-	400 lbs
Minced Meat	-	48 lbs
Beef	-	74 lbs
Cake	-	42 pieces
Fruit	-	43 tins
Milk	-	2 tins
Fish	-	5 tins
Meat	-	22 tins

ADULTERATIONS.

The law relating to the composition of food and drugs is administered by the County Council. The Food and Drugs Act, 1955, places restrictions on the addition of other substances to any food constituents. Probably the most important section in Part 1 of the Act is section 2, which relates to the sale of food and drugs which are not of the nature, substance or quality demanded by the purchaser. Most of the prosecutions which arise are in respect of offences under this section.

FACTORIES ACT, 1937
Part 1 of the Act.

1. Inspections in connection with health -

Premises	Number on Register	Inspections	Number of written Notices
(1) Factories in which Sections 1, 2,3,4 and 6 are to be enforced by Local Authorities	12	4	-
(2) Factories not included in (1) in which Section 7 is enforced by the Local Authority	47	39	1
(3) Other premises in which Section 7 is enforced by the Local Authority	17	12	-
Totals	76	55	1

Cases in which DEFECTS were found -

	<u>Found</u>	<u>Remedied</u>
Want of cleanliness - - -	1	1
Sanitary conveniences unsuitable or defective - - -	-	-
Not separate for sexes - - -	-	-

Mr. R.S. Moffett is H.M. Inspector of Factories for the Portsmouth District which includes Petersfield Urban District. His address is -
Princes House, Kings Terrace, Southsea - Telephone Portsmouth 24097.

METEOROLOGY.

A rain gauge was installed at the rear of the Town Hall, by the West Sussex River Board, readings commenced on 17th January, 1960.

RAINFALL 1962

	<u>Inches.</u>	<u>Fell in.</u>
January	5.37	20 days
February	0.57	8 days
March	1.52	10 days
April	3.11	16 days
May	2.68	16 days
June	0.51	8 days
July	2.18	11 days
August	4.55	13 days
September	5.01	14 days
October	2.23	10 days
November	3.32	15 days
December	3.14	14 days
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Total	34.19 inches	
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Longest period without memorable rain 18 days, 6th to 23rd October.

Largest amount on one day, 6th August, 2.05 inches.